CLAIM FORM - MEDICAL INSURANCE (INPATIENT VISIT)

IMPORTANT NOTE

1. *The policyholder and/or the insured person(s) must truthfully give information and particulars to the best knowledge and belief.*
2. *We are not admitting to any legal responsibility by accepting this claim form.*
3. *If the claim is found to be fraudulent, or if any fraudulent means or devices are used to obtain any policy benefits, the policy will be rendered void.*
4. *Notify or submit your claims to EQI as soon as possible as late claims notification may be a breach of policy condition. (please refer to policy wordings)*

Policy No.:

PARTICULARS OF POLICYHOLDER

Name of Policyholder:	
Name of Authorised Representative:	
Email:	Contact No.:

PARTICULARS OF CLAIMANT

Name of Claimant:		NRIC / FIN No.:
Date of Birth:	Contact No.:	Gender: ☐ Male ☐ Female
Date of Employment:	Plan No:	Occupation:

DETAILS OF ILLNESS / INJURY

Please state exactly what happened:

State nature of illness / injury:

Date & Time of accident / Date symptoms first commenced: _____

Date condition was first treated: _____

Is this a work-related injury: ☐ Yes ☐ No

Name and address of attending physician:

Has the insured person ever seen a doctor or been treated for any similar condition in the past? ☐ Yes ☐ No

If yes, please state date of previous treatment and name and address of attending doctor for previous treatment:

For road traffic accident claim, please confirm whether the accident involving third party? ☐ Yes ☐ No

If yes, please state:

(i) Vehicle No. of third party: _____

(ii) Motor Insurer of third party: _____

Have you claimed or do you intend to claim from any other insurer for this illness / injury? ☐ Yes ☐ No

If yes, please state all the claims submitted:

(i) Name of Insurer(s): _____

(ii) Details of law firm engaged (if any): _____

Do you have any other medical insurance with other insurer? ☐ Yes ☐ No

If yes, please state:

Name of the insurer(s): _____ Policy number(s): _____ Commencement date(s): _____

PAYMENT DETAILS (PLEASE CHOOSE THE PAYMENT MODE)

☐ PayNow Linked Account	PayNow registered name: _____ PayNow registered NRIC / FIN or mobile number: _____ PayNow registered UEN (for corporate account): _____
☐ Bank Transfer	Bank Name: _____ Bank account holder's name: _____ Bank account number: _____

NOTE: EQ INSURANCE COMPANY LIMITED shall not be liable for any losses incurred by you as a result of providing inaccurate PayNow registered details or bank account details.

(Letter of Authorisation is required if payee for PayNow Linked Account or Bank Transfer is not the insured)

DECLARATION, AUTHORISATION AND DATA PRIVACY CONSENT BY INSURED

I / We hereby declare and warrant the following:

1. All statements and answers provided in this form are complete, accurate, and true to the best of my / our knowledge and belief.
2. I / We understand that any false or fraudulent statements, as well as any attempt to conceal material facts related to this claim, may result in the forfeiture of all rights to claim under the policy. In such instances, EQ Insurance Company Limited ("EQI") reserves the right to report the matter to the police for further investigation.
3. In cases where I / we are not the policyholder, or in the scenario of a corporate policy, I / we confirm that I / we have been duly authorised by the insured member(s) (hereafter referred to as the 'Insured') to provide relevant information pertaining to the claims. I / we acknowledge full responsibility for ensuring the accuracy and validity of this submission. Furthermore, I / we agree to indemnify EQI against any losses or claims arising from this submission.
4. I / We authorise and consent to the release of any and all relevant information, as requested by EQI or its authorised representatives, from hospitals, doctors, individuals, or organizations that have provided medical care, conducted examinations, or maintain medical records for me / insured. This authorisation extends to disclosing details regarding illnesses, injuries, medical history, consultations, prescriptions, treatments, and any related medical records / certifications. In the case of a corporate policy, I / we confirm that I / we have gotten the same consent from the applicable insured(s) related to this claim. A photocopy of this authorisation shall be considered equally valid as the original.
5. I / We hereby grant permission and consent to EQI for the collection, usage, disclosure, and processing of my/our personal data. Additionally, I / we authorise the sharing of such pertinent information with EQI's authorised representatives, intermediaries, third-party service providers, reinsurers, legal entities involved in the claims process, government / regulatory bodies, industry associations, courts, and other dispute resolution forums, for the purposes and uses described in EQI's Personal Data Protection Statement available at www.eqinsurance.com.sg which is in alignment with legal, regulatory obligations, and risk management procedures.

_____	_____
Claimant's Signature	Policyholder's Signature (Affix company stamp, if applicable)
Name of Claimant: _____	Name of Authorized Representative: _____
Date: _____	Date: _____

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